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Recommendations for Improving the Home and Community-Based Services (HCBS) Quality Measure Set

Summary of a Workgroup Review of the 2028 HCBS Quality Measure Set

Final Report
January 2026

2028 HCBS QUALITY MEASURE SET REVIEW WORKGROUP MEMBERS

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Acronyms

CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-based entity
CIB	CMCS Informational Bulletin
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CQL	The Council on Quality and Leadership
FASI	Functional Assessment Standardized Items
FFS	Fee-for-service
HCBS	Home and community-based services
HHS	U.S. Department of Health and Human Services
HSRI	Human Services Research Institute
LTSS	Long-term services and supports
MFP	Money Follows the Person
MLTSS	Managed long-term services and supports
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NCI-AD™	National Core Indicators - Aging and Disability™
NCI®-IDD	National Core Indicators®- Intellectual and Developmental Disabilities
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
POM®	Personal Outcome Measures®
RTC/OM	Rehabilitation Research and Training Center on HCBS Outcome Measurement

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) and states have worked for many years to support increased access to high-quality home and community-based services (HCBS) for Medicaid beneficiaries. In 2022, CMS released the first official version of the HCBS Quality Measure Set[1] and in 2024, they released an updated measure set for voluntary reporting by states. The HCBS Quality Measure Set is intended to promote common and consistent use of the measures within and across states, allow CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS.

States are required to report measures from the HCBS Quality Measure Set every other year starting in 2028.[2] To update and maintain the measure set, CMS is required to periodically consult with interested parties about measure set updates, including which measures should be added to or removed from the HCBS Quality Measure Set.[3] CMS has indicated that it plans to make substantive updates to the measure set no more frequently than once every other year, which may include the addition or removal of measures.[4] CMS has also indicated that it intends to retain each of the measures in the measure set for at least five years to ensure the availability of longitudinal data, unless there are serious issues associated with the measures (such as related to measure reliability or validity) or states' use of the measures (such as excessive cost of state data collection and reporting or insurmountable technical issues with state reporting on the measures).[5] Technical corrections and minor revisions may be implemented more frequently.

CMS contracted with Mathematica to convene the 2028 HCBS Quality Measure Set Review Workgroup. The Workgroup was charged with assessing the existing measure set and recommending measures for removal from or addition, with the goal of strengthening and improving the 2028 HCBS Quality Measure Set. The Workgroup included 25 members representing a wide array of affiliations, subject matter expertise related to HCBS, and quality

[1] In State Medicaid Director Letter # 22-003, CMS described the quality measures included in the first official version of the HCBS Quality Measure Set and provided information on the purpose of the measure set, measure selection criteria, organization of the measure set, and considerations for implementation. CMS also provided additional information regarding each measure, including: (1) whether a measure is endorsed by a consensus-based entity (CBE); (2) its measure stewards; and (3) data collection methods. For more information, see https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

[2] 42 CFR 441.311(c).

[3] The list of interested parties who CMS must consult to periodically make updates to the HCBS Quality Measure Set is described at 42 CFR 441.312(g).

[4] 42 CFR 441.312(c)(1).

[5] https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

measurement and improvement experience[6] (see page ii for a list of Workgroup members). Workgroup members discussed and voted on measures suggested by the public for removal from or addition to the HCBS Quality Measure Set, using criteria described in Exhibit ES.1. These criteria are intended to support the adoption of measures that are feasible and viable for state-level reporting, are actionable by states to improve HCBS programs, and represent states' goals for improving service delivery and outcomes for Medicaid HCBS beneficiaries.

Exhibit ES.1. Criteria for the Removal and Addition of Measures in the 2028 HCBS Quality Measure Set

Criteria for Removal of Existing Measures	
Technical Feasibility	
A1.	The measure is being retired by the measure steward and will no longer be updated or maintained.
A2.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
A3.	The majority of states report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries receiving HCBS (or the ability to link to an identifier).
A4.	The specifications and data source do not allow for consistent calculations across states (e.g., there is meaningful variation in coding or data completeness across states).
Actionability and Strategic Priority	
B1.	Taken together with other HCBS Quality Measure Set measures, the measure does not contribute to estimating the overall national quality of HCBS service delivery or improving outcomes in Medicaid HCBS programs and does not contribute to the measure set in a way that justifies its inclusion while aligning with the goal of a parsimonious measure set.
B2.	The measure does not address a strategic priority for improving service delivery and outcomes in Medicaid HCBS programs (e.g., it does not address the most pressing needs of Medicaid beneficiaries receiving HCBS).
B3.	The measure cannot be stratified by any stratification categories used in other CMS programs. Considerations could include a lack of adequate sample and population sizes or lack of available data in the required data source(s).
B4.	The measure cannot be used to assess and compare state progress in improving HCBS service delivery and outcomes in Medicaid HCBS programs (e.g., the measure is topped out, trending is not possible, similar measure constructs cannot be measured across different survey instruments permitted within the measure set).
B5.	Improvement on the measure is outside the direct influence of Medicaid HCBS programs/providers.
B6.	The measure no longer aligns with priorities that are important for and important to Medicaid beneficiaries receiving HCBS.
B7.	Another measure is recommended for replacement and that other measure is: (1) more broadly applicable (across populations or disability types) for the topic, and/or (2) more proximal in time to desired outcomes for Medicaid beneficiaries receiving HCBS, and/or (3) more strongly associated with desired outcomes for Medicaid beneficiaries receiving HCBS.

[6] The list of interested parties who CMS must consult to periodically make updates to the HCBS Quality Measure Set is described at 42 CFR 441.312(g).

Exhibit ES.1 *(continued)*

Criteria for Removal of Existing Measures	
Other Considerations	
C1.	The measure does not produce reliable and meaningful state-level results, given Medicaid HCBS population sizes and demographics.
C2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
C3.	Including the measure in the HCBS Quality Measure Set could result in substantial additional data collection burden for providers or Medicaid beneficiaries receiving HCBS that outweighs the measure's benefits.
C4.	States may not be able to produce the measure for all relevant Medicaid HCBS populations within two years of the measure being added to the HCBS Quality Measure Set.

Criteria for Addition of New Measures	
Technical Feasibility (ALL criteria must be met for a measure to be discussed at the voting meeting)	
A1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets). (Specifications must be provided as part of the submission.)
A2.	The measure must have been tested in state Medicaid HCBS programs or be in use by one or more state Medicaid HCBS programs. (Documentation is required as part of the submission.)
A3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries receiving HCBS (or the ability to link to an identifier). (Evidence about the reliability and validity of measures is required as part of the submission, or an explanation for why such information is not available must be provided.)
A4.	The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness). (Documentation of data quality and consistency across states is required as part of the submission.)
A5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the HCBS Quality Measure Set.
Actionability and Strategic Priority	
B1.	Taken together with other measures in the HCBS Quality Measure Set, the measure can be used to estimate the overall national quality of HCBS service delivery, can be used to improve outcomes in Medicaid HCBS programs, or contributes to the measure set in a way that justifies its inclusion while aligning with the goal of a parsimonious measure set.
B2.	The measure addresses a strategic priority for improving service delivery and outcomes in Medicaid HCBS programs (e.g., it addresses the most pressing needs of beneficiaries receiving HCBS).
B3.	The measure can be stratified by one or more stratification categories used in other CMS programs. Considerations could include a lack of adequate sample and population sizes or lack of available data in the required data source(s).
B4.	The measure can be used to assess and compare state progress in improving HCBS service delivery and outcomes in Medicaid HCBS programs overall (e.g., the measure has room for improvement, performance is trendable, similar measure constructs can be measured across different survey instruments permitted within the measure set).
B5.	The measure aligns with priorities that are important for and important to Medicaid beneficiaries receiving HCBS.
B6.	The measure would fill a gap in the HCBS Quality Measure Set, would address an imbalance in data source types within the measure set, or would add value when compared to related measures that are already in the HCBS Quality Measure Set. (If this measure is being proposed as a replacement of an existing measure, a removal form must be submitted for the existing measure.)

Exhibit ES.1 *(continued)*

Criteria for Addition of New Measures	
Other Considerations	
C1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful state-level results, taking into account Medicaid HCBS population sizes and demographics.
C2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible.
C3.	Adding the measure to the HCBS Quality Measure Set does not result in substantial additional data collection burden for providers or Medicaid beneficiaries receiving HCBS relative to the measure's benefits.
C4.	States should be able to produce the measure for all relevant Medicaid HCBS populations within two years of the measure being added to the HCBS Quality Measure Set.
C5.	The code sets and codes specified in the measure must be in use by states or otherwise be readily available to states to support calculation of the measure.

Workgroup members convened virtually on April 8 and 9, 2025, to review 15 measures suggested for removal and 24 measures suggested for addition. The measures were organized by Mathematica into several domains informed by the National Quality Forum (NQF) 2016 HCBS Quality Framework.[7] The measures were presented, discussed, and voted on by domain. For a measure to be recommended for removal from or addition to the HCBS Quality Measure Set, at least two-thirds of the Workgroup members eligible to vote had to vote for removal or addition.

In summary, the Workgroup recommended removing three measures from the 2028 HCBS Quality Measure Set: *FFS LTSS/MLTSS-1: Comprehensive Assessment and Update (LTSS-1)*, *FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update (LTSS-2)*, and *FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider (LTSS-3)*. The Workgroup recommended adding four measures to the 2028 HCBS Quality Measure Set: *NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services, NCI-AD: Percentage Of People Who Know Whom To Contact If They Have A Complaint About Their Services, NCI-AD: Percentage Of People Who Have Access To Mental Health Services If They Want Them,* and *NCI-AD: Percentage Of People Who Have Needed Assistive Equipment And Devices* (Exhibit ES.2). This report summarizes the Workgroup's discussion and rationale for these recommendations.

[7] https://cms.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2028 HCBS Quality Measure Set

Measure Name	Domain	Measure Steward
Measures Recommended for Removal		
FFS LTSS/MLTSS-1: Comprehensive Assessment and Update	Person-Centered Planning and Coordination	CMS
FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update	Person-Centered Planning and Coordination	CMS
FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider	Person-Centered Planning and Coordination	CMS
Measures Recommended for Addition		
NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services	Choice and Control	NASDDDS and HSRI
NCI-AD: Percentage Of People Who Know Whom To Contact If They Have A Complaint About Their Services	Service Delivery and Effectiveness	ADvancing States and HSRI
NCI-AD: Percentage Of People Who Have Access To Mental Health Services If They Want Them	Holistic Health and Functioning	ADvancing States and HSRI
NCI-AD: Percentage Of People Who Have Needed Assistive Equipment And Devices	Holistic Health and Functioning	ADvancing States and HSRI

FFS = Fee-For-Service; MLTSS = Managed Long-Term Services and Supports; NCI-AD = National Core Indicators-Aging and Disabilities; NCI-IDD = National Core Indicators-Intellectual and Developmental Disabilities; NASDDDS = The National Association of State Directors of Developmental Disabilities Services; HSRI = Human Services Research Institute.

To inform future reviews, the Workgroup discussed gap areas in the 2024 HCBS Quality Measure Set. The Workgroup identified gaps in population-specific measures, particularly for children and young adults, as well as gaps related to caregiver support, employment, effective community transitions, and workforce issues. During this discussion, Workgroup members also expressed concern about the potential burden on states resulting from CMS's biennial updates to the measure set, noting that frequent substantive changes may limit states' ability to adequately prepare for and report on new measures.

This report summarizes the Workgroup's review, discussion, and recommendations. CMS will consider the Workgroup's recommendations and public comments to inform decisions about updates to the 2028 HCBS Quality Measure Set. CMS expects to release the proposed 2028 HCBS Quality Measure Set for public comment in the Federal Register by early calendar year 2026 and publish the final 2028 HCBS Quality Measure Set by the end of calendar year 2026.

Introduction

The Centers for Medicare & Medicaid Services (CMS) and states have worked for many years to support increased access to high-quality home and community-based services (HCBS) for Medicaid beneficiaries. HCBS are optional Medicaid benefits that can be provided as an alternative to institutional care, allowing individuals with disabilities to receive needed services and supports in their homes and communities.[8] Over the past decade, the U.S. Department of Health and Human Services (HHS), states, and other entities have taken a number of steps to strengthen the capacity of states and the federal government to monitor, oversee, and improve the quality and effectiveness of services, and to assure beneficiary health and safety.

In 2022, CMS released the first HCBS Quality Measure Set for voluntary use by states. The purpose of the HCBS Quality Measure Set is to promote common and consistent use of quality measures within and across states, allow CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS.

CMS published an updated 2024 HCBS Quality Measure Set, which includes 65 nationally standardized quality measures for Medicaid-funded HCBS. CMS also released a CMCS Informational Bulletin (CIB) that requires states and territories participating in the Money Follows the Person (MFP) Demonstration to report on a subset of mandatory measures from the HCBS Quality Measure Set beginning in the fall of 2026. Starting in 2028, all states are required to report every other year on a set of measures in the HCBS Quality Measure Set. [9] Furthermore, CMS is required to periodically consult with interested parties about which measures should be added to or removed from the HCBS Quality Measure Set.[10] CMS has indicated that it plans to make substantive updates to the measure set no more frequently than once every other year, which may include the addition or removal of measures.[11] CMS has also indicated that it intends to retain each of the measures in the measure set for at least five years to ensure the availability of longitudinal data, unless there are serious issues associated with the measures (such as related to measure reliability or validity) or states' use of the measures (such as excessive cost of state data collection and reporting or insurmountable technical issues with state reporting on the measures).[12] Technical corrections and minor revisions may be implemented more frequently.[13]

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[8] https://www.medicaid.gov/media/141531.

[9] 42 CFR 441.311(c).

[10] The list of interested parties who CMS must consult to periodically make updates to the HCBS Quality Measure Set is described at 42 CFR 441.312(g).

[11] 42 CFR 441.312(c)(1).

[12] https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

[13] 42 CFR 441.312(c)(2).

CMS contracted with Mathematica to convene the 2028 HCBS Quality Measure Set Workgroup. The Workgroup was charged with assessing the existing HCBS Quality Measure Set and recommending measures for removal or addition, with the goal of strengthening and improving the 2028 HCBS Quality Measure Set. The Workgroup included 25 members representing a wide array of affiliations, subject matter expertise related to HCBS, and quality measurement and improvement experience (see page ii for a list of Workgroup members). Workgroup members discussed and voted on measures for removal from or addition to the HCBS Quality Measure Set, based on several criteria. These criteria support the adoption of measures that are feasible and appropriate for state-level reporting, are actionable by states to improve HCBS programs, and represent states' goals for improving care delivery and health outcomes for Medicaid HCBS beneficiaries

This report provides an overview of the HCBS Quality Measure Set, describes the 2028 HCBS Quality Measure Set Review process, and summarizes the Workgroup's recommendations for improving the measure set.

Overview of the HCBS Quality Measure Set

The 2024 HCBS Quality Measure Set includes 65 measures that assess quality across a broad range of domains identified as measurement priorities for HCBS. The HCBS Quality Measure Set includes measures that are calculated using administrative and/or case management records, as well as measures derived from several experience of care surveys, which assess the experience of care of one or more population groups included in HCBS programs, including HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®), National Core Indicators®-Intellectual and Developmental Disabilities (NCI®- IDD), National Core Indicators Aging and Disability (NCI-AD)™, and Personal Outcome Measures (POM)®. Appendix A lists the 2024 HCBS Quality Measure Set measures. While the HCBS Quality Measure Set contains a select number of measures from each of the experience of care surveys, states reporting on those measures are required to field the full survey to their beneficiaries receiving HCBS, as applicable.

Description of the 2028 HCBS Quality Measure Set Review Process

This section describes the 2028 HCBS Quality Measure Set Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2028 HCBS Quality Measure Set Review included 25 voting members representing state Medicaid programs, managed care plans, professional associations, universities, hospitals, health care companies, and other organizations across the country. The Workgroup members for the 2028 Review are listed on page ii of this report.

The Workgroup offered expertise in HCBS programs and reporting requirements, Money Follows the Person (MFP) demonstrations, and HCBS service delivery and case management. Their expertise spanned a wide range of populations served by HCBS programs, including older adults; people with intellectual or developmental disabilities (I/DD), physical disabilities, brain injuries, serious mental illness/serious emotional disturbance, and substance use disorders; and children with complex medical conditions. In addition, Workgroup members brought expertise in quality measurement methods and data sources, including the feasibility of using Medicaid data for HCBS quality measurement.

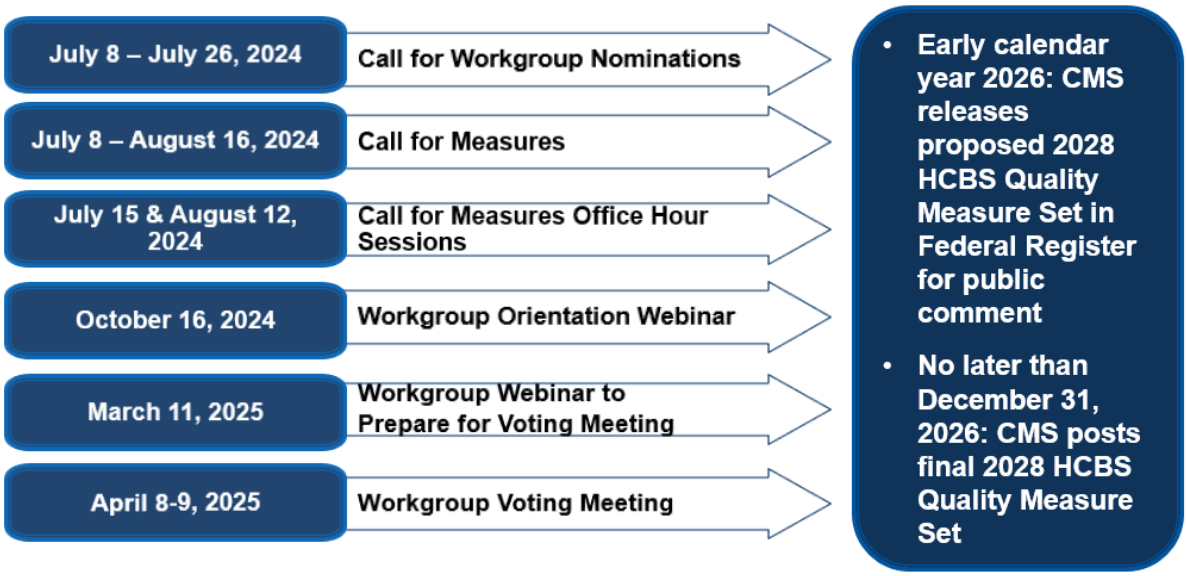
Although Workgroup members had individual areas of subject matter expertise, and some were nominated by an organization, they were asked to participate as stewards of Medicaid HCBS as a whole and not represent their individual organizational points of view. The Workgroup was charged with considering which measures would best drive improvement in care delivery and health outcomes for Medicaid beneficiaries receiving HCBS.

Mathematica required Workgroup members to submit a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could create a conflict of interest (or the appearance of one) related to the HCBS Quality Measure Set measures or other measures reviewed during the Workgroup process. Workgroup members deemed to have an interest in a measure under consideration were recused from voting on that measure.

Workgroup Timeline and Meetings

Mathematica held virtual meetings via webinar in October 2024 and March 2025 to orient Workgroup members to the 2028 HCBS Quality Measure Set Review process and to prepare them for the voting meeting, which took place in April 2025 (Exhibit 1). All meetings were open to the public, with public comment encouraged during each meeting.

Exhibit 1. Timeline for 2028 HCBS Quality Measure Set Review Workgroup



Public Call for Measures

On behalf of CMS, Mathematica issued a Public Call for Measures as part of CMS's process to make updates to the HCBS Quality Measure Set. During this period, members of the public were invited to suggest measures to consider for addition to or removal from the HCBS Quality Measure Set. Measures suggested for addition to or removal from the HCBS Quality Measure Set would be considered by CMS in finalizing the 2028 HCBS Quality Measure Set, which will be the first mandatory reporting cycle for all states. Mathematica hosted two virtual Call for Measures Office Hour sessions in July and August 2024 to share information and answer questions about the Call for Measures process. During these office hour sessions, Mathematica presented an overview of the technical feasibility criteria, described the process for suggesting measures for addition or removal, and invited members of the public to ask questions about the process.

To focus the Call for Measures for the 2028 HCBS Quality Measure Set Review on measures that are a good fit for the HCBS Quality Measure Set, Mathematica presented the criteria for addition and removal in three areas. The following is a high-level overview of the criteria. Exhibit 2 on the following page contains the full list of the criteria shared with the Workgroup and the public to guide the Public Call for Measures.

- **Technical feasibility criteria.** Workgroup members and the public considered the measure's technical feasibility when suggesting either the removal of an existing measure or the addition of a new measure. However, the specific criteria and requirements differ by type of suggestion (removal or addition).
    - **Technical feasibility criteria** (applies to measures suggested for removal). A measure could be suggested for removal if the submitter identified significant feasibility challenges for HCBS Quality Measure Set reporting. For example, a measure could be suggested for removal if (1) most states experience significant challenges in accessing a data source that includes all the data elements needed to calculate the measure or (2) the specifications and data source do not allow for consistent calculations across states.
    - **Minimum technical feasibility and appropriateness criteria** (applies to measures suggested for addition). As noted in Exhibit 2, measures suggested for addition must meet all minimum technical feasibility requirements to be considered by the Workgroup. For example, measures must have detailed technical specifications that enable production of the measure at the state level and must have been field tested or used in a state Medicaid HCBS program according to the technical specifications.

- **Actionability criteria** (applies to measures suggested for addition or removal). For example, measures suggested for addition should provide useful and actionable results that can be used to drive improvement in HCBS delivery and outcomes in Medicaid HCBS programs, and they should fill a gap in, or add value to, the existing measures on the HCBS Quality Measure Set. Conversely, a measure could be suggested for removal if improvement on the measure is outside the influence of Medicaid HCBS providers or programs, or if a stronger replacement measure is available with broader applicability or closer alignment with desired outcomes.
- **Other considerations** (applies to measures suggested for addition or removal). For example, measures suggested for addition should align with measures used in other CMS programs and should be specified using code sets and codes available to states. Conversely, a measure could be removed if it does not produce reliable and meaningful state-level results, or if all states might not be able to produce the measure for all Medicaid HCBS populations within two years of it being added to the HCBS Quality Measure Set.

Exhibit 2. Criteria for the Removal and Addition of Measures in the 2028 HCBS Quality Measure Set

Criteria for Removal of Existing Measures	
Technical Feasibility	
A1.	The measure is being retired by the measure steward and will no longer be updated or maintained.
A2.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
A3.	The majority of states report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries receiving HCBS (or the ability to link to an identifier).
A4.	The specifications and data source do not allow for consistent calculations across states (e.g., there is meaningful variation in coding or data completeness across states).
Actionability and Strategic Priority	
B1.	Taken together with other HCBS Quality Measure Set measures, the measure does not contribute to estimating the overall national quality of HCBS service delivery or improving outcomes in Medicaid HCBS programs and does not contribute to the measure set in a way that justifies its inclusion while aligning with the goal of a parsimonious measure set.
B2.	The measure does not address a strategic priority for improving service delivery and outcomes in Medicaid HCBS programs (e.g., it does not address the most pressing needs of Medicaid beneficiaries receiving HCBS).
B3.	The measure cannot be stratified by any stratification categories used in other CMS programs. Considerations could include a lack of adequate sample and population sizes or lack of available data in the required data source(s).
B4.	The measure cannot be used to assess and compare state progress in improving HCBS service delivery and outcomes in Medicaid HCBS programs (e.g., the measure is topped out, trending is not possible, similar measure constructs cannot be measured across different survey instruments permitted within the measure set).
B5.	Improvement on the measure is outside the direct influence of Medicaid HCBS programs/providers.

Exhibit 2 *(continued)*

Criteria for Removal of Existing Measures	
B6.	The measure no longer aligns with priorities that are important for and important to Medicaid beneficiaries receiving HCBS.
B7.	Another measure is recommended for replacement and that other measure is: (1) more broadly applicable (across populations or disability types) for the topic, and/or (2) more proximal in time to desired outcomes for Medicaid beneficiaries receiving HCBS, and/or (3) more strongly associated with desired outcomes for Medicaid beneficiaries receiving HCBS.
Other Considerations	
C1.	The measure does not produce reliable and meaningful state-level results, given Medicaid HCBS population sizes and demographics.
C2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
C3.	Including the measure in the HCBS Quality Measure Set could result in substantial additional data collection burden for providers or Medicaid beneficiaries receiving HCBS that outweighs the measure's benefits.
C4.	States may not be able to produce the measure for all relevant Medicaid HCBS populations within two years of the measure being added to the HCBS Quality Measure Set.

Criteria for Addition of New Measures	
Technical Feasibility (ALL criteria must be met for a measure to be discussed at the voting meeting)	
A1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets). (Specifications must be provided as part of the submission.)
A2.	The measure must have been tested in state Medicaid HCBS programs or be in use by one or more state Medicaid HCBS programs. (Documentation is required as part of the submission.)
A3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries receiving HCBS (or the ability to link to an identifier). (Evidence about the reliability and validity of measures is required as part of the submission, or an explanation for why such information is not available must be provided.)
A4.	The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness). (Documentation of data quality and consistency across states is required as part of the submission.)
A5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the HCBS Quality Measure Set.
Actionability and Strategic Priority	
B1.	Taken together with other measures in the HCBS Quality Measure Set, the measure can be used to estimate the overall national quality of HCBS service delivery, can be used to improve outcomes in Medicaid HCBS programs, or contributes to the measure set in a way that justifies its inclusion while aligning with the goal of a parsimonious measure set.
B2.	The measure addresses a strategic priority for improving service delivery and outcomes in Medicaid HCBS programs (e.g., it addresses the most pressing needs of beneficiaries receiving HCBS).
B3.	The measure can be stratified by one or more stratification categories used in other CMS programs. Considerations could include a lack of adequate sample and population sizes or lack of available data in the required data source(s).

Exhibit 2 *(continued)*

Criteria for Addition of New Measures	
B4.	The measure can be used to assess and compare state progress in improving HCBS service delivery and outcomes in Medicaid HCBS programs overall (e.g., the measure has room for improvement, performance is trendable, similar measure constructs can be measured across different survey instruments permitted within the measure set).
B5.	The measure aligns with priorities that are important for and important to Medicaid beneficiaries receiving HCBS.
B6.	The measure would fill a gap in the HCBS Quality Measure Set, would address an imbalance in data source types within the measure set, or would add value when compared to related measures that are already in the HCBS Quality Measure Set. (If this measure is being proposed as a replacement of an existing measure, a removal form must be submitted for the existing measure.)
Other Considerations	
C1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful state-level results, taking into account Medicaid HCBS population sizes and demographics.
C2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible.
C3.	Adding the measure to the HCBS Quality Measure Set does not result in substantial additional data collection burden for providers or Medicaid beneficiaries receiving HCBS relative to the measure's benefits.
C4.	States should be able to produce the measure for all relevant Medicaid HCBS populations within two years of the measure being added to the HCBS Quality Measure Set.
C5.	The code sets and codes specified in the measure must be in use by states or otherwise be readily available to states to support calculation of the measure.

Members of the public used online forms to submit their suggestions for removal or addition. The submission forms were structured to collect key information about each measure and assess the extent to which the measure aligned with the criteria described previously. For example, individuals who suggested adding a measure were asked to provide the name and contact information for the measure steward, a link to or copy of the technical specifications, a rationale for the submission, information about whether the measure had been tested in or currently used by state Medicaid HCBS programs, and a description of the potential challenges states could face in calculating the measure. Individuals who suggested removing a measure were asked to select one or more reasons for removal from a pre-determined list aligned with the criteria and then to explain their rationale. The form also asked them to assess whether removal of the measure would leave a gap in the measure set.

The Call for Measures was open from July 8 to August 16, 2024. Members of the public suggested 15 measures for removal and 30 measures for addition. Mathematica assessed the measures suggested for addition and determined that the Workgroup would not discuss six of these measures due to incomplete submissions and/or failure to meet the technical feasibility criteria. Exhibit 3 lists the six measures suggested for addition that were not discussed by the Workgroup due to lack of testing or use in Medicaid HCBS programs, or an incomplete submission by the measure nominator.

Exhibit 3. Measures Suggested for Addition That Were Not Discussed by the Workgroup

Measure Name	Measure Steward	Data Source
Money Follows the Person Quality of Life Survey	CMS, Mathematica	Survey
Person-Centered Outcome Measurement Scale: Goal Identification	NCQA	Case Management Records
Person-Centered Outcome Measurement Scale: Goal Follow-up	NCQA	Case Management Records
Person-Centered Outcome Measurement Scale: Goal Achievement	NCQA	Case Management Records
HCBS CAHPS: Supplemental Employment Module - Works for Pay	CMS	Survey
HCBS CAHPS: Supplemental Employment Module - Wants to Work for Pay	CMS	Survey

CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; HCBS CAHPS = Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems.

After Mathematica's review of the suggestions, the Public Call for Measures resulted in 39 suggested measures for discussion during the April 2025 voting meeting:

- 15 measures suggested for removal from the HCBS Quality Measure Set
- 24 measures suggested for addition to the HCBS Quality Measure Set

Orientation Meeting

During the orientation meeting on October 16, 2024, Mathematica introduced the Workgroup members and outlined the disclosure of interest process, the Workgroup's charge, timeline, and process for the 2028 HCBS Quality Measure Set Review. The meeting also included a review of the Public Call for Measures, including the process and results.

Mathematica provided an overview of the Public Call for Measures, including the criteria for suggesting measures for addition and removal, as well as the results of the Public Call for Measures.

CMS provided introductory remarks about the Workgroup's charge, emphasizing the importance of selecting a set of measures that supports long-term quality improvement across HCBS programs. CMS also highlighted the finalization of the *Ensuring*

Workgroup Charge

The 2028 HCBS Quality Measure Set Review Workgroup was charged with assessing the existing measure set and recommending measures for removal or addition to strengthen and refine the HCBS Quality Measure Set.

The Workgroup should recommend measures that are feasible for state Medicaid HCBS program reporting and create a balance between the desirability and viability of measures from the perspective of state-level quality measurement and improvement.

Access to Medicaid Services final rule (Access Rule), which introduced a new framework for oversight, monitoring, and quality improvement in Medicaid HCBS programs.[14]

Meeting to Prepare for the 2028 Review

The second meeting took place March 11, 2025, to help Workgroup members prepare for the discussion at the 2028 HCBS Quality Measure Set Review voting meeting. In this meeting, Mathematica provided support to Workgroup members with preparing for the measure discussions, including listing the measures for review, describing the criteria to consider when making measure recommendations, identifying resources available to facilitate their review, and previewing the voting process that would be used. These resources included a packet containing detailed Measure Information Sheets for measures suggested for removal from or addition to the HCBS Quality Measure Set and a resource that showed the domains for the measures suggested for addition and the other measures in those domains in the 2024 HCBS Quality Measure Set.[15] Mathematica also shared a technical specifications packet that contained proprietary technical specifications for some of the measures suggested for addition to the HCBS Quality Measure Set and a measure review worksheet. Workgroup members were asked to review all materials related to the measures; complete the measure review worksheet with their questions and preliminary votes; and attend the voting meeting prepared with notes, questions, and preliminary votes on the suggested measures.

Mathematica also shared the approach to measure discussion that would be used at the voting meeting. To facilitate Workgroup discussion, Mathematica organized the measure set and suggested measures into nine domains based on the topic addressed (Exhibit 4): (1) Choice and Control, (2) Consumer Leadership and Development, (3) System Performance and Accountability[16], (4) System Performance and Accountability[17], (5) Person-Centered Planning and Coordination, (6) Community Inclusion[18], (7) Access and Resource Allocation, (8) Holistic Health and Functioning, and (9) Human and Legal Rights. These domains[19] build on the domains used by CMS to classify the measures in the 2024 HCBS Quality Measure Set, which are informed by the National Quality Forum 2016 HCBS Quality Framework. Appendix B lists the measures for discussion by domain. Exhibit 4 summarizes the number of measures from the

[14] https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

[15] Most of these resources were also made available to the public in the 2028 Resources tab of the HCBS Quality Measure Set Review webpage: https://mathematica.org/features/hcbsqmsreview.

[16] The System Performance and Accountability Domain includes rebalancing measures.

[17] The Service Delivery and Effectiveness Domain includes workforce measures.

[18] The Community Inclusion Domain includes measures of employment, non-medical transportation, social connectedness and relationships, and community participation.

[19] These domains were adapted from the National Quality Forum HCBS Quality Measure Framework. One domain in that framework (Caregiver Support) is not included in this list, as there are no measures in the 2024 HCBS Quality Measure Set, suggested for addition, or suggested for removal that fall into that domain.

2024 HCBS Quality Measure Set in each domain, as well as the number in each domain suggested for addition or removal.

Exhibit 4. Distribution of 2024 HCBS Quality Measure Set and Suggested Measures, by Domain

Domain	2024 Measures	Suggested for Removal	Suggested for Addition
Person-Centered Planning and Coordination	9	3	0
Choice and Control	9	0	9
Consumer Leadership and Development	0	0	1
Service Delivery and Effectiveness	11	2	1
Holistic Health and Functioning	12	3	3
System Performance and Accountability	3	1	1
Community Inclusion	10	1	5
Access and Resource Allocation	3	2	0
Human and Legal Rights	8	3	4

Voting Meeting to Review Measures for the 2028 HCBS Quality Measure Set

The 2028 HCBS Quality Measure Set Review voting meeting took place virtually on April 8 and 9, 2025. Workgroup members, measure stewards, and members of the public participated in the meeting. Representatives from CMS attended the meeting to listen to the discussion.

The measure discussion was organized by domain. Voting took place by domain after the Workgroup discussion and public comment on all measures in that domain. Each measure was considered and voted on in its specified form. For each domain, Mathematica reviewed the measures suggested for addition or removal and facilitated a discussion of the measures. Mathematica elicited comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. For each domain, an opportunity for public comment followed the Workgroup discussion.

Voting took place after the Workgroup discussion and public comment period for each domain. Mathematica facilitated two rounds of voting within each domain: first for the measures that were suggested for removal, and then for the measures that were suggested for addition. Workgroup members voted electronically through a secure, web-based polling application during specified voting periods.

For each measure suggested for removal, Workgroup members could select "Yes, I recommend removing this measure from the HCBS Quality Measure Set" or "No, I do not recommend removing this measure from the HCBS Quality Measure Set." For each measure suggested for addition, Workgroup members could select "Yes, I recommend adding this measure to the HCBS

Quality Measure Set" or "No, I do not recommend adding this measure to the HCBS Quality Measure Set."

For a measure to be recommended for removal or addition, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of removal or addition. Mathematica adjusted the two-thirds voting threshold according to the number of eligible[20] Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported whether the results met the two-thirds threshold.

On the second day of the meeting, the Workgroup also discussed gap areas in the 2024 HCBS Quality Measure Set that could be addressed by future Calls for Measures to strengthen and improve the measure set. A summary of this discussion is presented later in this report. Workgroup co-chairs provided final remarks at the end of the meeting and offered reflections.

Workgroup Recommendations for Improving the 2028 HCBS Quality Measure Set

The Workgroup recommended removing three measures from the HCBS Quality Measure Set, all from the Person-Centered Planning and Coordination Domain: *FFS LTSS/MLTSS-1: Comprehensive Assessment and Update (LTSS-1)*, *FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update (LTSS-2)*, and *FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider (LTSS-3)*. The Workgroup recommended adding four measures to the 2028 HCBS Quality Measure Set: *NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services*, *NCI-AD: Percentage Of People Who Know Whom To Contact If They Have A Complaint About Their Services*, *NCI-AD: Percentage Of People Who Have Access To Mental Health Services If They Want Them*, and *NCI-AD: Percentage Of People Who Have Needed Assistive Equipment And Devices* (Exhibit 5).

This section summarizes the Workgroup's discussion and rationale for these recommendations. Appendix C provides information about the measures discussed during the voting meeting that were not recommended for either removal from or addition to the HCBS Quality Measure Set. Measure Information Sheets for each measure the Workgroup considered are available on the Mathematica HCBS Quality Measure Set Review website.[21]

[20] During some of the measure votes, certain Workgroup members were asked to abstain from voting on specific measures due to conflicts of interest (for example, if the Workgroup member is employed by the organization that developed the measure). Workgroup members that did not need to abstain were eligible to vote on whether to recommend the measure for addition to or removal from the HCBS Quality Measure Set.

[21] The Measure Information Sheets for measures suggested for addition and removal are available at https://mathematica.org/-/media/internet/features/2025/hcbs-quality-measure-set/qmsreview-mis.pdf.

Exhibit 5. Workgroup Recommendations for Updates to the 2028 HCBS Quality Measure Set

Measure Name	Domain	Measure Steward
Measures Recommended for Removal		
FFS LTSS/MLTSS-1: Comprehensive Assessment and Update	Person-Centered Planning and Coordination	CMS
FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update	Person-Centered Planning and Coordination	CMS
FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider	Person-Centered Planning and Coordination	CMS
Measures Recommended for Addition		
NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services	Choice and Control	NASDDDS and HSRI
NCI-AD: Percentage of People Who Know Whom to Contact if They Have a Complaint about Their Services	Service Delivery and Effectiveness	ADvancing States and HSRI
NCI-AD: Percentage of People Who Have Access to Mental Health Services if They Want Them	Holistic Health and Functioning	ADvancing States and HSRI
NCI-AD: Percentage of People Who Have Needed Assistive Equipment and Devices	Holistic Health and Functioning	ADvancing States and HSRI

CMS = Centers for Medicare & Medicaid Services; FFS = Fee-For-Service; MLTSS = Managed Long-Term Services and Supports; NCI-AD = National Core Indicators-Aging and Disabilities; NCI-IDD = National Core Indicators-Intellectual and Developmental Disabilities; HSRI = Human Services Research Institute.

Person-Centered Planning and Coordination Domain

Person-centered planning is an approach to assessment, planning, and coordination of services and supports that is focused on the individual's goals, needs, preferences, and values. The person directs the development of the plan, which describes the life they want to live in the community. Services and supports are coordinated across providers and systems to carry out the plan and ensure fidelity with the person's expressed goals, needs, preferences, and values. Measures in the Person-Centered Planning and Coordination Domain measure the extent to which an individual's service plan development and the coordination of their services adhere to a person-centered approach.

Three measures within this domain were discussed by the Workgroup, all of which were recommended for removal. These three measures (*FFS LTSS/MLTSS-1: Comprehensive Assessment and Update [LTSS-1]*, *FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update [LTSS-2]*, and *FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider [LTSS-3]*) are measures that are constructed using case management records.

Measures Recommended for Removal

Some Workgroup members expressed support for keeping LTSS-1 and LTSS-2 in the HCBS Quality Measure Set, citing the measures as an opportunity to standardize the information

collected about beneficiaries for the purposes of person-centered planning, as well as creating a standard set of expectations of the contents of a person-centered service plan. Additionally, during the discussion of measure gap areas, Workgroup members who supported keeping the measures cited that their states had already invested significant resources in preparing to report these measures since so many states are on an accelerated reporting timeline because they are Money Follows the Person demonstration grant recipients. Several Workgroup members advocated for the removal of these measures – as well as LTSS-3 – emphasizing that all three of these measures assess compliance rather than quality of care. Multiple Workgroup members also commented that the value of these measures is not worth the high administrative burden states will experience collecting and reporting them, due to the manual effort associated with reviewing case management records in many states. Three Workgroup members noted that similar, compliance-based measures are often highly scored, providing limited opportunity for further improvement and generating few insights into actual quality of care. One Workgroup member noted that when their state uses compliance measures, reporters are motivated to comply with the bare minimum rather than focus on improving the quality of support that an HCBS beneficiary receives.

During the public comment period, representatives from ADvancing States, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and Oregon's Department of Human Services commented on the high administrative burden and low relative benefit associated with requiring states to report LTSS-1 and LTSS-2 as part of the HCBS Quality Measure Set. The representative from ADvancing States noted that these measures were originally developed for managed care plans as a way to ensure that they were performing the core functions necessary to deliver LTSS to the individuals they serve. They emphasized that using these measures in a fee-for-service environment places excessive administrative burden and expense on states, whose case management systems are not designed to collect these types of elements in structured fields that can be extracted for measure reporting. The representative from Oregon's Department of Human Services agreed with this point, commenting that collecting and reporting these measures would require a complete system overhaul in Oregon, as all of their HCBS programs are fee-for-service.

The representative from NASDDDS emphasized that the necessary elements of these two measures do not align with what is typically collected by state I/DD systems, noting that some of the core elements in the comprehensive assessment measure were not developed or tested for people with I/DD. The representative described these measures as a "mismatch" with what would be considered a comprehensive assessment and robust person-centered plan in the I/DD system, and that compelling states to incorporate these elements would have a negative impact on the I/DD system.

A public commenter from Iowa Medicaid expressed support for keeping these measures in the HCBS Quality Measure Set, commenting that it is important to look comprehensively at a person's needs.

Choice and Control Domain

The Choice and Control Domain includes measures that assess the extent to which individuals who use HCBS, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered. Nine survey-based measures within this domain were discussed for addition to the HCBS Quality Measure Set, one of which was recommended for addition by the Workgroup: *NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services*.

Measure Recommended for Addition

The *NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change Services* measure is a single-item, survey-based measure for adults with I/DD. Though this was the only measure in the Choice and Control Domain recommended for addition of the nine suggested, neither the Workgroup members nor public commenters made any specific comments about this measure. The discussion about Choice and Control measures which were not recommended for addition and include eight other survey-based measures is summarized in Appendix C.

Service Delivery and Effectiveness Domain

The Service Delivery and Effectiveness Domain includes measures that assess the level to which services and supports are provided in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. This domain also includes workforce measures, which measure the adequacy, availability, and appropriateness of the paid HCBS workforce.

One measure within this domain was suggested for addition to the HCBS Quality Measure Set and was recommended for addition by the Workgroup: *NCI-AD: Percentage of People Who Know Whom to Contact if They Have a Complaint about Their Services*. This measure is a single-item, survey-based measure for older adults and adults with physical disabilities.

Measure Recommended for Addition

During discussion of the measure, two Workgroup members noted that it should not be added to the HCBS Quality Measure Set because it is compliance focused. Conversely, two other Workgroup members thought that the compliance focus would be beneficial to states, as this measure could help states to track progress on federal grievance-related requirements.[22] One Workgroup member commented that this measure would be analogous to the NCI-IDD measure that was recommended for addition to the HCBS Quality Measure Set: *NCI-IDD: The Percentage of People who Report that They Know Whom to Talk to if they Want to Change*

[22] 42 CFR 441.301(c)(7), 42 CFR 441.464(d)(5), 42 CFR 441.555(e), and 42 CFR 441.745(a)(1)(iii).

Services. Another Workgroup member appreciated that there is variation in state rates on this measure, suggesting that there are opportunities for states to improve.

During the public comment period, representatives from ADvancing States and from the University of Illinois both expressed support for adding this measure to the HCBS Quality Measure Set. The representative from the University of Illinois noted that some HCBS beneficiaries may not know who their case manager is, making this a valuable measure for states to track. The representative from ADvancing States agreed with Workgroup members that this measure could be a rough measure of the extent to which state activities to educate beneficiaries about the existence of a grievance and appeals system have been effective.

Holistic Health and Functioning Domain

The Holistic Health and Functioning Domain includes measures that examine the extent to which all dimensions of holistic health are assessed and supported.

Three measures within this domain were discussed for addition to the HCBS Quality Measure Set, two of which were recommended for addition by the Workgroup: *NCI-AD: Percentage of People Who Have Needed Assistive Equipment and Devices* and *NCI-AD: Percentage of People Who Have Access to Mental Health Services if They Want Them*. These are both survey-based measures for older adults and adults with physical disabilities.

Measures Recommended for Addition

The *NCI-AD: Percentage of People Who Have Needed Assistive Equipment and Devices* measure is a composite measure that assesses nine separate items that is an indicator of whether someone needs but does not have the specified device (wheelchair, scooter, walker, hearing aids, glasses, personal emergency response system, oxygen machine, other assistive technology, or some other equipment). Three Workgroup members voiced approval for adding this measure to the HCBS Quality Measure Set, though one noted that the relatively low percentage of individuals in the most recent results who indicated that they need but do not have assistive technology suggests that there may not be much room for improvement on this measure. Another Workgroup member commented that research has shown that there are disparities in access to assistive equipment and devices, which could indicate an opportunity to learn from stratification of this measure.

The *NCI-AD: Percentage of People Who Have Access to Mental Health Services if They Want Them* measure is a single-item measure. Multiple Workgroup members expressed concern that access to mental health services is not within direct control of the HCBS system, with one expressing concern that state HCBS programs could be held accountable to address issues that are not within their sphere of influence. Another Workgroup member countered that this measure can be an indicator of effective or ineffective care coordination for HCBS beneficiaries with mental health conditions.

During the public comment period, a representative from the Oregon Department of Human Services noted that fee-for-service HCBS programs face greater challenges coordinating services across systems, and that provider capacity issues within the mental health system could affect states' performance on this measure, subjecting them to corrective action plans from CMS. A representative from ADvancing States commented that CMS has not yet indicated what the benchmarks will be for measures in the HCBS Quality Measure Set, and inclusion of a measure in the measure set should not be based on whether quality improvement plans may be required. A Workgroup member commented that it is important that states with fee-for-service HCBS programs be held accountable to the same standards as states where HCBS programs are integrated into managed care, and that fee-for-service states have leverage to increase provider capacity across systems.

Workgroup Discussion of Gaps in the HCBS Quality Measure Set

During the 2028 HCBS Quality Measure Set Review, Mathematica asked Workgroup members to identify perceived gap areas in the 2024 measure set to inform future HCBS Quality Measure Set Reviews. Mathematica asked each Workgroup member to mention one gap area they think is a priority to address or to endorse a gap area mentioned by another Workgroup member. The Workgroup members identified the following gap areas in the HCBS Quality Measure Set:

- **Comparable measures for all HCBS populations.** Multiple Workgroup members commented that it would be valuable to include comparable measures across the multiple experience of care surveys that states can select from in their HCBS Quality Measure Set reporting, as this would facilitate the measurement of consistent constructs across disability groups, regardless of the survey instrument that a state chooses to adopt. One Workgroup member suggested that it would be helpful to have a resource that maps each measure to the specific population to which it applies.
- **Measures for children.** Several Workgroup members noted that the HCBS Quality Measure Set lacks measures for individuals under the age of 18 who receive HCBS. One Workgroup member emphasized that several states have HCBS waivers that provide services to children, and measuring the quality of these services is critical. Another Workgroup member indicated that the population of children with HCBS needs is growing and has become increasingly expensive. Multiple individuals shared that measures from the 2024 measure set could be adapted to reflect the experience of younger populations; one added that new measures should also be developed. Separately, there was a suggestion to validate proxy-reported versions of measures that would allow for the family or caregiver to report on the experience of beneficiaries ages 18 to 21.
- **Caregiver support measures.** Several Workgroup members emphasized the need to capture the family caregiver experience, specifically the supports they need to provide care for their

loved one. One suggested a survey that would collect information on whether family caregivers have access to respite services, training, and peer supports.

- **Health outcome measures for individuals with complex medical needs.** Two Workgroup members suggested including quality measures that address the significant health care needs of HCBS beneficiaries. They shared that HCBS environments have become better equipped for supporting the management of complex health conditions. For example, one individual shared that pediatric HCBS beneficiaries often require more skilled services, in part because personal care needs are primarily met by family members. One individual suggested using Medicaid administrative data to include information on individual health outcomes, such as emergency room use.
- **Employment measures.** Workgroup members expressed interest in adding measures related to employment, such as access to and quality of employment services, which they indicated was a gap in the 2024 HCBS Quality Measure Set. One individual suggested that this could be accomplished by leveraging currently available measures on employment that are included in several of the experience of care surveys.
- **Measures of successful community transitions.** Two Workgroups members shared that the HCBS Quality Measure Set is missing information on transitions of care from institutional settings to the community. The intent would be to examine the success of community transitions, such as by assessing the timeframe in which an individual remains in the community post-discharge.
- **Measures tracking minimum standards for assessments and person-centered planning.** The Workgroup voted to recommend the removal of LTSS-1 and LTSS-2 from the HCBS Quality Measure Set. If these measures are removed from the HCBS Quality Measure Set, two Workgroup members noted that they felt this could result in a gap in assessing minimum standards for assessment and person-centered service plans. One suggested addressing this gap by including standards—less stringent than the LTSS-1 and LTSS-2 measures—in program technical guidance and program-specific contracts. Another Workgroup member noted that, without a universal comprehensive assessment, assessment-based outcome measures are not comparable.

Workgroup members suggested the need for measures in several other areas to address existing gaps in the measure set. This included companion measures for mental health services for other HCBS populations, similar to the *NCI-AD: Percentage of People Who Have Access to Mental Health Services if They Want Them* measure that was recommended by the Workgroup members. Another Workgroup member observed that the 2016 National Quality Forum report includes a *workforce* domain that is absent from the HCBS Quality Measure Set. They proposed including workforce measures to assess ongoing workforce activity—the individual noted that both NCI surveys now include efforts to gather workforce information. One Workgroup member suggested measuring whether HCBS beneficiaries are receiving adequate service by measuring the difference between services authorized and services utilized. Other suggestions were measures

around the appeals process, expanding the use of the HCBS Quality Measure Set to state plan HCBS, and one suggestion from a public commenter related to the inclusion of dental care measures.

In addition to identifying gaps in measure topics, Workgroup members raised concerns about various data collection and measurement challenges within the HCBS Quality Measure Set. One Workgroup member expressed concern about the measure set's reliance on many single-item measures rather than composite measures. The Workgroup member noted that single-item measures may provide direct insight, but the commenter felt that these measures introduce more error in the data relative to composite measures. Additionally, one Workgroup member noted that some of the HCBS Quality Measure Set measures appear to be more focused on compliance than on HCBS beneficiary outcomes, though another expressed a preference for the inclusion of measures that help states comply with waiver assurance reporting. One Workgroup member shared that there may be measurement gaps across individual, provider, and state levels, which indicates a need to explore ways to better coordinate efforts across these levels of data collection. Separately, interest in real-time data on the quality measures could help facilitate timely engagement by managed care plans and states, according to one Workgroup member.

Multiple Workgroup members also provided feedback on the biennial review process. These individuals noted that states invest substantial time and resources to redesign data systems to collect data for measures calculated using case management data. Given the potential changes to the HCBS Quality Measure Set, two Workgroup members expressed additional concerns about states investing time and resources to adopt these measures only for the measures to later be removed from the measure set. One individual suggested that the HCBS Quality Measure Set be limited to measures from experience of care surveys or those that can be calculated using claims data, as these are less costly and administratively burdensome.

Several Workgroup members noted that some of the suggested Rehabilitation Research and Training Center on HCBS Outcome Measurement (RTC/OM) measures[23] could fill important gaps in the HCBS Quality Measure Set. However, because these measures are specified for provider rather than state-level reporting, Workgroup members expressed concerns about the potential for data collection burden for states and providers reporting these measures.

[23] RTC/OM survey measures assess HCBS beneficiary outcomes in eight domains. The measures are modular, meaning that they are designed for providers to administer select measures independently without administering the full survey. For more information, please visit: https://rtcom.umn.edu/rtcom-measures.

Next Steps

The 2028 HCBS Quality Measure Set Review Workgroup recommended removing three measures within the Person-Centered Planning and Coordination Domain from the HCBS Quality Measure Set. Workgroup members felt these measures were overly focused on compliance rather than quality and noted that they impose a high administrative burden on states while offering limited value. The Workgroup recommended adding four new measures to the HCBS Quality Measure Set: one under the Choice and Control Domain, one under the Service Delivery and Effectiveness Domain, and two under the Holistic Health and Functioning Domain. Workgroup members noted that the compliance-focused measure recommended for addition to the Service Delivery and Effectiveness Domain could help states track progress on requirements outlined in the Access Rule.[24] The measures recommended for addition to the Holistic Health and Functioning Domain were seen by Workgroup members as having strong potential to drive improvement and expand access to services.

The Workgroup discussed several gap areas in the HCBS Quality Measure Set. These include the fact that many survey-based measures do not have comparable measures across populations, the need for consideration for the cost and administrative burden on states, the lack of measures for children, and no – or few – measures in key domains of HCBS quality, including employment, caregiver support, effective community transitions, and workforce.

The first HCBS Quality Measure Set Review took place following the finalization of the Access Rule, which requires states to report every other year on the HCBS Quality Measure Set, and describes the process for updating and maintaining the HCBS Quality Measure Set.[25] Workgroup member discussions revealed concerns about limited state capacity and burden placed on states when adhering to frequent changes to reporting requirements.

CMS will review this final report to inform decisions about updates to the 2028 HCBS Quality Measure Set. CMS expects to release the proposed draft 2028 HCBS Quality Measure Set in the Federal Register for public comment in late 2025. The final 2028 HCBS Quality Measure Set will be posted in the Federal Register by December 31, 2026.

[24] https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

[25] 42 CFR 441.311(c).

Appendix A.
HCBS Quality Measure Set Measures

Exhibit A.1. 2024 Home and Community-Based Services Quality Measure Set, by Measure Steward and Data Source

CBE #	Measure Steward	Measure Name	Data Source/Data Collection Method
2967	CMS	HCBS CAHPS: Choosing the services that matter to you (Questions 56, 57)	Survey
2967	CMS	HCBS CAHPS: Community Inclusion and Empowerment Composite Measure (Questions 75, 77, 78, 79, 80, 81)	Survey
2967	CMS	HCBS CAHPS: Personal Safety & Respect Composite Measure (Questions 64, 65, 68)	Survey
2967	CMS	HCBS CAHPS: Physical Safety Single-Item Measure (Question 71)	Survey
2967	CMS	HCBS CAHPS: Staff Are Reliable and Helpful Composite Measure (Questions 13, 14, 15, 19, 37, 38)	Survey
2967	CMS	HCBS CAHPS: Staff Listen and Communicate Well Composite Measure (Questions 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, 45)	Survey
2967	CMS	HCBS CAHPS: Transportation to Medical Appointments Composite Measure (Questions 59, 61, 62)	Survey
2967	CMS	HCBS CAHPS: Unmet Needs Single-Item Measures (Questions 18, 22, 25, 27, 40)	Survey
3593	CMS	FASI-1: Identification of Person-Centered Priorities[c]	Case Management Record
3594	CMS	FASI-2: Documentation of a Person-Centered Service Plan[c]	Case Management Record
NA	CMS	HCBS-10: Self-Direction of Services and Supports Among Medicaid Beneficiaries Receiving LTSS Through Managed Care Organizations	Case Management Record
NA	CMS	FFS LTSS/MLTSS-1: Comprehensive Assessment and Update[a,b,c,d]	Case Management Record
NA	CMS	FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update[a,b,c,d]	Case Management Record
NA	CMS	FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider[a,b,d]	Case Management Record
NA	CMS	FFS LTSS/MLTSS-4: Reassessment and Person-Centered Plan Update after Inpatient Discharge[a,b,d]	Case Management Record
NA	CMS	MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls[d]	Case Management Record
NA	CMS	FFS LTSS/MLTSS-6: Admission to a Facility from the Community[a,d]	Administrative
3457	CMS	FFS LTSS/MLTSS-7: Minimizing Facility Length of Stay[a,d]	Administrative
NA	CMS	FFS LTSS/MLTSS-8: Successful Transition after Long-Term Facility Stay[a,d]	Administrative
NA	NCQA	MLTSS: Plan All-Cause Readmission (HEDIS)	Administrative
NA	Advancing States, HSRI	NCI-AD: Percentage of non-English speaking participants who receive information about their services in the language they prefer	Survey

Exhibit A.1 *(continued)*

CBE #	Measure Steward	Measure Name	Data Source/Data Collection Method
NA	Advancing States, HSRI	NCI-AD: Percentage of people in group settings who have enough privacy where they live	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who are able to see or talk to their friends and family when they want to	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who are as active in their community as they would like to be	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who are ever worried for the security of their personal belongings	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who can choose or change their support staff	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who can choose or change what kind of services they get	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who can choose or change when and how often they get their services	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who feel safe around their support staff	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who had adequate follow-up after being discharged from a hospital or rehabilitation/nursing facility	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who had somebody talk or work with them to reduce their risk of falling or being unstable	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who have transportation to get to medical appointments when they need to	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who have transportation when they want to do things outside of their home	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people who know how to manage their chronic conditions	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people whose money was taken or used without their permission in the last 12 months	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people whose service plan reflects their preferences and choices	Survey

Exhibit A.1 *(continued)*

CBE #	Measure Steward	Measure Name	Data Source/Data Collection Method
NA	ADvancing States, HSRI	NCI-AD: Percentage of people whose support staff do things the way they want them done	Survey
NA	ADvancing States, HSRI	NCI-AD: Percentage of people whose support staff show up and leave when they are supposed to	Survey
3622	NASDDDS, HSRI	NCI-IDD CC-3: Can Stay Home When Others Leave (The proportion of people who live with others who report they can stay home if they choose when others in their house/home go somewhere)	Survey
3622	NASDDDS, HSRI	NCI-IDD CC-4: Life Decision Composite Measure (The proportion of people who report making choices (independently or with help) in life decisions)	Survey
3622	NASDDDS, HSRI	NCI-IDD CI-1: Social Connectedness (The proportion of people who report that they do not feel lonely)	Survey
3622	NASDDDS, HSRI	NCI-IDD CI-3: Transportation Availability Scale (The proportion of people who report adequate transportation)	Survey
3622	NASDDDS, HSRI	NCI-IDD HLR-1: Respect for Personal Space Scale (The proportion of people who report that their personal space is respected in the home)	Survey
3622	NASDDDS, HSRI	NCI-IDD PCP-2: Person-Centered Goals (The proportion of people who report their service plan includes things that are important to them)	Survey
3622	NASDDDS, HSRI	NCI-IDD PCP-5: Satisfaction with Community Inclusion Scale (The proportion of people who report satisfaction with the level of participation in community inclusion activities)	Survey
NA	NASDDDS, HSRI	NCI-IDD preventive screening single-item measures: Percentage of people who are reported to have received preventive health screenings within recommended time frames (physical exam, routine dental exam, vision screening, hearing test, mammogram, pap test, colorectal cancer screening)	Survey
NA	NASDDDS, HSRI	NCI-IDD: Percentage of people who report their staff come and leave when they are supposed to	Survey
NA	NASDDDS, HSRI	NCI-IDD: Percentage of people who report that they helped make their service plan	Survey
NA	CQL	POM: People are free from abuse and neglect	Survey
NA	CQL	POM: People choose services	Survey
NA	CQL	POM: People have the best possible health	Survey
NA	CQL	POM: People interact with other members of the community	Survey
NA	CQL	POM: People live in integrated environments	Survey
NA	CQL	POM: People participate in the life of the community	Survey
NA	CQL	POM: People realize personal goals	Survey

Source: Centers for Medicare & Medicaid Services, 2024 Home and Community-Based Services Quality Measure Set, CMCS Informational Bulletin, April 11, 2024. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib041124.pdf.

Exhibit A.1 *(continued)*

Notes: This measure list is organized by measure name, which reflects the data source and data element(s). Please refer to the State Medicaid Director Letter cited above for more details on how the measures address the section 1915(c) wavier assurances and sub assurances and whether they can be used to assess access, rebalancing, and/or community integration.

[a] The FFS version of the equivalent MLTSS measure was added to the 2024 HCBS Quality Measure Set.

[b] For measures with a HEDIS equivalent, states can opt to use the HEDIS equivalent for their managed care and FFS populations.

[c] At a state's option, FASI-1 can be used in place of FFS LTSS-1/MLTSS-1, and FASI-2 can be used in place of FFS LTSS-2/MLTSS-2; FASI-1 and FASI-2 are not expected to be used by all states implementing the measure set and instead are included only as options in place of MLTSS-1/FFS LTSS-1/MLTSS-1 and FFS LTSS-2/MLTSS-2, respectively.

[d] Technical specifications for these measures are available at https://www.medicaid.gov/license/form/8586/3396.

CBE = Consensus-based entity; CMS = Centers for Medicare & Medicaid Services; CQL = The Council on Quality and Leadership; FASI = Functional Assessment Standardized Items; FFS = Fee-For-Service; HCBS = Home and Community-Based Services; HCBS CAHPS = HCBS Consumer Assessment of Healthcare Providers and Systems; HSRI = Human Services Research Institute; MLTSS = Managed Long-Term Services and Supports; NA = Not endorsed by CBE; NASDDDS = National Association of State Directors of Developmental Disability Services; NCI-AD = National Core Indicators–Aging and Disabilities; NCI-IDD = National Core Indicators–Intellectual and Developmental Disabilities; NCQA = National Committee for Quality Assurance; POM = Personal Outcome Measures.

Appendix B.
Measures Suggested for Addition to or Removal from the HCBS Quality Measure Set for Workgroup Discussion, By Domain

Exhibit B.1. Measures for Discussion, by Domain

Domain	Suggested for Addition	Suggested for Removal
Choice and Control	• NCI-IDD: Are there rules about having friends or visitors in your home? • NCI-IDD: Do staff do things the way you want them to be done? • NCI-IDD: If you want to change something about your services, do you know who to talk to? • NCI-IDD: The percentage of people reported to be using a self-directed supports option • NCI-AD: Percentage of people in group settings who are able to choose their roommate • NCI-AD: Percentage of people in group settings who are able to furnish and decorate their room however they want to • NCI-AD: Percentage of people in group settings who are able to lock the door to their room • RTC/OM: Personal Choices and Goals - Self-Determination Index • RTC/OM: Services and Supports - Self-Determination Index	None
Consumer Leadership and Development	• RTC/OM: System Supports Meaningful Consumer Involvement	None
System Performance and Accountability[a]	• Health Plan CAHPS: Health Plan Satisfaction Q26	• FFS LTSS/MLTSS-7: Minimizing Facility Length of Stay
Community Inclusion[b]	• RTC/OM: Experiences Seeking Employment • RTC/OM: Experiences Using Transportation • RTC/OM: Job Experiences Survey • RTC/OM: Meaningful Activity • RTC/OM: Social Connectedness	• NCI-AD: Percentage of people who are able to see or talk to their friends and family when they want to
Access and Resource Allocation	None	• NCI-AD: Percentage of non-English speaking participants who receive information about their services in the language they prefer • HCBS CAHPS: Transportation to Medical Appointments Composite Measure (Questions 59, 61, 62)

Exhibit B.1 *(continued)*

Domain	Suggested for Addition	Suggested for Removal
Holistic Health and Functioning	• NCI-AD: Percentage of people who have access to mental health services if they want them • NCI-AD: Percentage of people who can get an appointment to see or talk to their primary care doctor when they need to • NCI-AD: Percentage of people who have needed assistive equipment and devices	• NCI-AD: Percentage of people with concerns about falling who had someone work with them to reduce risk of falls • NCI-AD: Percentage of people who know how to manage their chronic conditions • MLTSS: Plan All-Cause Readmission (HEDIS)
Human and Legal Rights	• NCI-AD: Percentage of people in group settings who always have access to food • RTC/OM: Feelings of Safety Around Others • RTC/OM: Knowledge of Abuse and Neglect and How to Report It • RTC/OM: Freedom from Experiences of Abuse and Neglect	• NCI-AD: Percentage of people who are ever worried for the security of their personal belongings • NCI-AD: Percentage of people who feel safe around their support staff • NCI-AD: Percentage of people whose money was taken or used without their permission in the last 12 months
Person-Centered Planning and Coordination	None	• FFS LTSS/MLTSS-1: Comprehensive Assessment and Update • FFS LTSS/MLTSS-2: Comprehensive Person-Centered Plan and Update • FFS LTSS/MLTSS-3: Shared Person-Centered Plan with Primary Care Provider
System Delivery and Effectiveness[c]	• NCI-AD: Percentage of people who know whom to contact if they have a complaint about their services	• NCI-AD: Percentage of people who had adequate follow-up after being discharged from a hospital or rehabilitation/nursing facility • HCBS CAHPS: Staff Listen and Communicate Well

[a] The System Performance and Accountability Domain includes measures of rebalancing.

[b] The Community Inclusion Domain includes measures of employment, non-medical transportation, social connectedness and relationships, and community participation.

[c] The System Delivery and Effectiveness Domain includes workforce measures.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; FFS = Fee-For-Service; HCBS = Home and Community-Based Services; MLTSS = Managed Long-Term Services and Supports; NCI-AD = National Core Indicators-Aging and Disabilities; NCI-IDD = National Core Indicators-Intellectual and Developmental Disabilities; RTC/OM = Rehabilitation Research and Training Center on HCBS Outcome Measurement.

Appendix C.
Summary of 2028 HCBS Quality Measure Set Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures discussed by the Workgroup but not recommended for removal from or addition to the HCBS Quality Measure Set, as they did not meet the two-thirds (67 percent) voting threshold by the Workgroup. The discussion took place during the Workgroup voting meeting on April 8 and 9, 2025. The summary is organized by domain.

Choice and Control Domain

The Choice and Control Domain is defined as the level to which individuals who use HCBS, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered. Nine measures from this domain were suggested for addition to the HCBS Quality Measure Set, one of which (*NCI-IDD: The Percentage of People Who Report That They Know Whom to Talk to if They Want to Change Services*) was recommended for addition. The eight measures suggested but not recommended for addition are:

- NCI-AD: Percentage of People in Group Settings Who Are Able to Choose Their Roommate (52 percent of the Workgroup voted to recommend adding this measure)
- NCI-AD: Percentage of People in Group Settings Who Are Able to Furnish and Decorate Their Room However They Want To (61 percent of the Workgroup voted to recommend adding this measure)
- NCI-AD: Percentage of People in Group Settings Who Are Able to Lock the Door to Their Room (65 percent of the Workgroup voted to recommend adding this measure)
- NCI-IDD: The Percentage of People who Report That There are Rules About Having Friends or Visitors at Home (30 percent of the Workgroup voted to recommend adding this measure)
- NCI-IDD: The Percentage of People Reported to Be Using a Self-Directed Supports Option (13 percent of the Workgroup voted to recommend adding this measure)
- NCI-IDD: The Percentage of People who Report Staff Do Things the Way They Want Them Done (52 percent of the Workgroup voted to recommend adding this measure)
- Research and Training Center on HCBS Outcome Measurement (RTC/OM): Personal Choices and Goals – Self-Determination Index (29 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Services and Supports – Self-Determination Index (33 percent of the Workgroup voted to recommend adding this measure)

Measures Considered and Not Recommended for Addition

A cross-cutting theme during Workgroup discussion of the eight measures in this domain that were not recommended for addition was that many of the proposed measures were focused on a specific subgroup of HCBS recipients and lacked broader applicability or parallel measures for

other HCBS populations. Workgroup members also provided broad feedback on the RTC/OM measures that are applicable to the remaining domains.

The three NCI-AD measures in this domain—*Percentage of People in Group Settings Who Are Able to Choose Their Roommate, Percentage of People in Group Settings Who Are Able to Furnish and Decorate Their Room However They Want To*, and *Percentage of People in Group Settings Who Are Able to Lock the Door to Their Room*—measure the experience of people living in residential settings. One Workgroup member asked about the proportion of HCBS beneficiaries who receive in-home support as compared to those in residential placements. A representative from the Human Services Research Institute (HSRI), one of the measure stewards, noted that these measures are relevant to approximately a quarter of survey respondents and assess elements of the HCBS Settings Rule. One Workgroup member shared that the suggestion to add these measures to the HCBS Quality Measure Set may be due to their alignment with the requirements of the HCBS Settings Rule—however, the Workgroup member indicated that states are tracking and reporting compliance elsewhere and that other measures under consideration better address quality. Several Workgroup members expressed concern about whether the lack of applicability of these measures to other populations, such as individuals receiving in-home supports, is a limitation of their usefulness. In contrast, two Workgroup members shared that, despite the measures' focus on group residential settings, they are important to determine compliance with the HCBS Settings Rule. One Workgroup member questioned the validity of some of the single-item measures (for example, in the *NCI-AD: Percentage of People in Group Settings Who Are Able to Choose Their Roommate* measure), expressing concern that it may reflect variation in the way survey respondents might interpret the question which could impact the measures' comparability across states.

The Workgroup also considered the addition of the *NCI-IDD: The Percentage of People who Report That There are Rules About Having Friends or Visitors at Home* measure. One Workgroup member expressed concern that this measure may not capture appropriate flexibility with regard to visitors under the HCBS Settings Rule. The Workgroup also discussed the *NCI-IDD: The Percentage of People Reported to Be Using a Self-Directed Supports Option* measure. One Workgroup member expressed concern that variability in implementation of self-direction across states could create inconsistencies with implementation and therefore hinder state comparisons. Multiple Workgroup members noted state variation in uptake of self-direction, and one person expressed that this is not a quality-focused measure that reflects provider performance, rather it presents information on the characteristics (e.g., preferences, service use) of the population. One Workgroup member commented that although it is critical to collect data on utilization of self-direction, this measure would only capture the experience of HCBS beneficiaries with I/DD. Another Workgroup member remarked that self-directed supports, while important, may not be the best option for all individuals and suggested that information on use of self-directed supports may be better obtained from Medicaid program administrative data, rather than experience of care surveys.

Two Workgroup members expressed concerns about the validity of the single-item measure, *NCI-IDD: The Percentage of People who Report Staff Do Things the Way They Want Them Done*. One commented that the phrasing of this question could be interpreted differently by survey respondents, raising concerns about the consistency and comparability of responses. Another Workgroup member remarked that a response to this question would be reliant on countless interactions over a period of time, which might not produce information that is actionable for HCBS providers or state Medicaid programs.

Workgroup members shared overarching comments about the suggestion to add several measures based on the RTC/OM survey instrument. These comments were both broadly about the instrument itself and its administration, as well as specific feedback on the *RTC/OM Personal Choices* and *Goals – Self-Determination Index* and *Services and Supports – Self-Determination Index* measures in this domain. One Workgroup member expressed concerns that the measure is specified for provider-level reporting rather than state-level reporting. They emphasized that the time and resources required to implement the instrument might significantly burden providers. Several Workgroup members shared that a composite score may not drive meaningful action, as it may be difficult to identify what specific areas require attention and intervention. Another Workgroup member asked whether the survey instrument is proprietary and whether there is a fee to use the measures. One Workgroup member noted concerns about how "staff members" are defined in the *Services and Supports – Self-Determination Index* that comprises the composite score. Specifically, they were concerned that ongoing staffing shortages experienced by HCBS providers make it challenging for states to support meaningful performance improvement, making the measure less suitable for comparing state progress. Representatives from the measure steward (Institute on Community Integration – University of Minnesota) explained that previous research indicated that examining self-determination item by item provides limited value. Rather, they identified variation between two specific areas, personal choices and goals, and services and supports—which led them to develop the two Self-Determination Index measures. Moreover, they noted that use of a composite score is consistent with best practices of developing psychometric measures in the standards of psychological and educational measurement. Finally, the measure steward shared that the measures are not proprietary and are intended to be used publicly, free of charge.

During the public comment period for measures in this domain, commenters shared differing opinions on whether the HCBS Quality Measure Set should include measures of compliance with federal requirements – such as section 1915(c) waiver assurances – or measures that indicate whether a state's HCBS system is providing quality services to individuals receiving HCBS. A representative from ADvancing States, which is both a membership association of state HCBS agencies and one of the measure stewards for NCI-AD measures, commented that the HCBS Quality Measure Set was initially developed for both quality measurement and to support state compliance with reporting requirements for section 1915(c) waiver assurances. They also said that the three proposed NCI-AD measures in this domain are related to compliance with the HCBS Settings Rule but contribute little to evaluating overall quality of a state's HCBS system. One individual from the Virginia Department of Medical Assistance

Services inquired whether the NCI-IDD measure on self-directed supports would flag a state as non-compliant if a low percentage of individuals utilize self-directed supports. One commenter noted that states choose to offer self-direction and should not be penalized for low self-direction rates—while another stated that the measure is not suitable as a quality measure. One representative from Wyoming expressed that the RTC/OM measures include valuable questions, however they questioned whether the responses for some of the more specific questions produce results that are actionable for states.

Consumer Leadership and Development Domain

Measures in the Consumer Leadership and Development Domain assess the extent to which individuals who use HCBS are well supported to actively participate in the design, implementation, and evaluation of the system at all levels. One measure from this domain was suggested but not recommended for addition to the HCBS Quality Measure Set:

- RTC/OM: System Supports Meaningful Consumer Involvement (43 percent of the Workgroup voted to recommend adding this measure)

Measure Considered and Not Recommended for Addition

Two Workgroup members expressed support for including a measure of consumer involvement in the HCBS system but were concerned that this measure is specified for provider-level reporting rather than state-level reporting. The measure steward noted that, though the measure is specified for provider-level reporting, it is possible to aggregate and compare this measure across providers within a state.

There were no public comments on this measure.

System Performance and Accountability Domain

Measures in the System Performance and Accountability Domain assess the extent to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes. This domain includes measures of rebalancing. One measure from this domain was suggested for removal from the HCBS Quality Measure Set, and one was suggested for addition. Neither measure was recommended by the Workgroup.

Measure Considered and Not Recommended for Removal

The measure considered but not recommended for removal was the *FFS LTSS/MLTSS-7: Minimizing Facility Length of Stay* measure (LTSS-7). Thirty-five percent of the Workgroup voted to recommend removing this measure. One of the individuals who suggested removal of the measure noted that the *FFS LTSS/MLTSS-8: Successful Transition After Long-Term Facility Stay* measure (LTSS-8) more appropriately assesses health plans' and states' ability to provide care coordination and services. One Workgroup member noted differences in each measure's

specifications. Workgroup members sought clarification on several details in the LTSS-7 measure's technical specifications, including the target age group for the measure as well as the continuous enrollment period requirement. They noted that, though the technical specifications for the LTSS-7 measure indicate a focus on individuals ages 18 and older, the measure allows inclusion of facilities providing mental health services for individuals under age 21. The measure steward confirmed that the measure is limited to individuals ages 18 and older, and that an individual with 160 days of continuous enrollment in Medicaid LTSS following admission to a facility would be included the measure. However, the measure steward invited the Workgroup member to submit their more specific questions about continuous enrollment to the HCBS quality mailbox.

One Workgroup member remarked that there is a gap in the measure's specifications due to the exclusion of children under 18. Several Workgroup members provided input on the role of the measure in assessing the extent to which short-term facility stays result in discharges to the community as well as the role of HCBS in supporting those transitions. However, multiple Workgroup members expressed concerns that, for dually-eligible individuals, this measure is outside of the control of state HCBS programs, because the first 100 days of their stay in a facility would generally be covered by Medicare, not Medicaid. Workgroup members felt that this measure would hold states accountable for facility stays over which they have no influence. The measure steward did not address this concern directly, but confirmed that the measure is limited to discharges within 100 days of admission.

During the public comment period for this measure suggestion, one individual from Oregon's Department of Human Services, Aging and People with Disabilities expressed concerns that workforce and capacity limitations among providers may pose challenges in supporting individuals who have a longer stay before discharge, given that they perceive these individuals to have more complex needs. Moreover, they commented that this measure may incentivize inappropriately early discharges to ensure the state is aligning with measure expectations, which could be counter to beneficiary preferences.

Measure Considered and Not Recommended for Addition

The measure that was suggested for addition and not recommended by the Workgroup was the *Health Plan CAHPS: Health Plan Satisfaction* measure. Nine percent of the Workgroup voted to recommend adding this measure. One Workgroup member was concerned about the potential for confusion among respondents who might receive multiple Health Plan CAHPS surveys given variations in dual eligible designations (that is, whether an individual is partially or fully dually eligible for Medicare and Medicaid) qualifying them for different services as well as the potential for them to have non-aligned managed health care plans for Medicare and Medicaid. Several Workgroup members questioned why the numerator only includes respondents who rate their plan a 10 and does not include ratings of 8 and 9, which are included in top-box ratings for CAHPS in some settings. Other Workgroup members inquired about the scope of the question, whether responses might capture an individual's experience with a health plan and not

necessarily the HCBS received, and if this measure accounts for instances where an HCBS waiver is separate from a health plan. The measure steward was unable to attend the voting meeting to answer these questions.

During the public comment period, two individuals shared that while the *Health Plan CAHPS: Health Plan Satisfaction* measure serves an integral role in understanding beneficiary experience with a health plan, they were unclear whether it would be appropriate to assess the HCBS experience or whether the survey would be applicable only to Medicaid plans offering an LTSS benefit. One of the individuals also indicated that the addition of this measure would lead to the adoption of a managed care measure without a corresponding fee-for-service measure. The public commenter also agreed with earlier comments related to scoring health plans, noting that NCQA defines ratings of 8, 9, and 10 as a top-box score.

Service Delivery and Effectiveness Domain

Measures in the Service Delivery and Effectiveness Domain measure the level to which services and supports are provided in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes. This domain includes workforce measures, which assess the adequacy, availability, and appropriateness of the paid HCBS workforce. Two measures from this domain were suggested but not recommended for removal from the HCBS Quality Measure Set:

- HCBS CAHPS: Staff Listen and Communicate Well (57 percent of the Workgroup voted to recommend removing this measure)
- NCI-AD: Percentage of People who Had Adequate Follow-Up After Being Discharged from a Hospital or Rehabilitation/Nursing Facility (43 percent of the Workgroup voted to recommend removing this measure)

Measures Considered and Not Recommended for Removal

One Workgroup member supported removal of the *HCBS CAHPS: Staff Listen and Communicate Well* measure. Several Workgroup members agreed, expressing concerns with the wording of the survey questions that make up the measure, which could suggest that a staff member's accent is an indicator of poor communication. The Workgroup members suggested coordination with the measure steward to refine those two questions, given general support for the remaining questions included in the composite measure. One Workgroup member raised concerns about the construct validity of all the questions in the measure, questioning whether it accurately captures what it is intended to assess. During the discussion a Workgroup member also shared that a single question may not adequately reflect the range of interactions that a beneficiary has had with staff, given mixed experiences with staff.

Workgroup members noted that the *NCI-AD: Percentage of People who Had Adequate Follow-Up After Being Discharged from a Hospital or Rehabilitation/Nursing Facility* measure is

important for assessing HCBS and measure results produce actionable insight for the state to improve service delivery. Two Workgroup members raised concerns about the use of the term "adequate," with one individual noting that receiving a follow-up service does not necessarily mean that the follow-up care was "adequate." A representative from HSRI, one of the measure stewards for NCI-AD measures, noted that each respondent, based on their own opinion, determines whether the follow-up is adequate. However, they shared that the actual survey question only asks whether follow-up occurred, despite the measure name including a reference to adequate follow-up. One Workgroup member remarked that the measure lacks clarity on who is responsible for providing the follow-up and how follow-up is defined.

One public comment was received related to the two measures that were suggested but not recommended for removal in this domain. The individual echoed Workgroup concerns with the wording of the questions in the *HCBS CAHPS: Staff Listen and Communicate Well* measure. Despite their reservations, they felt that voting to remove the measure would be premature. Rather, they suggested sharing the concerns with AHRQ, the measure steward, for their consideration to inform efforts to refine the survey.

Community Inclusion Domain

Measures in the Community Inclusion Domain assess the extent to which people who receive HCBS are integrated into their communities and are socially connected in accordance with their personal preferences. This domain is intended to include measures of employment, non-medical transportation, social connectedness, and community participation. One measure from this domain was suggested but not recommended for removal from the HCBS Quality Measure Set:

- NCI-AD: Percentage of People Who are Able to See or Talk to Their Friends and Family When They Want to (43 percent of the Workgroup voted to recommend removing this measure)

Five measures from this domain were suggested but not recommended for addition:

- RTC/OM: Experiences Seeking Employment (43 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Experiences Using Transportation (29 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Job Experiences (29 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Meaningful Activity (29 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Social Connectedness (38 percent of the Workgroup voted to recommend adding this measure)

Measure Considered and Not Recommended for Removal

The Workgroup did not recommend removing *NCI-AD: Percentage of People Who are Able to See or Talk to Their Friends and Family When They Want to* from the HCBS Quality Measure Set. Several Workgroup members supported the removal of this measure, noting that the reasons beneficiaries are unable to see their family and friends are often out of the state's control. However, other Workgroup members opposed removal of this measure, noting that the measure could act as a proxy for measuring loneliness among HCBS beneficiaries and expressed concern over removing this topic from the measure set. The measure steward clarified that the NCI-AD survey has several other measures of loneliness. However, none of those measures were suggested for addition to the HCBS Quality Measure Set. One Workgroup member emphasized that data collection for this measure could highlight issues regarding access to family or friends for those living in alternative care facilities and could prompt targeted training by the state for those facilities. Another Workgroup member confirmed this comment by highlighting that their state has successfully collaborated with its survey vendors to implement interventions based on survey results. Finally, a Workgroup member highlighted that the HCBS Quality Measure Set currently contains a measure related to loneliness specific to people with I/DD and adding a more general measure about loneliness should be a goal for the Workgroup for future reviews.

During the public comment period, a representative from the Oregon Department of Human Services expressed concern about keeping this measure in the HCBS Quality Measure Set. They noted that it is inappropriate to treat this measure as a proxy for loneliness, as the question must be asked as written and does not specifically ask beneficiaries whether they are lonely. A commenter from the University of Illinois Chicago opposed removal of this measure and emphasized that the measure can be used to assess whether providers are facilitating access to families and friends through interventions like providing transportation or resources for HCBS beneficiaries to connect online with others.

Measures Considered and Not Recommended for Addition

The Workgroup voted on whether to add five measures from the RTC/OM survey related to employment, transportation, and social connectedness but did not recommend adding any of them to the HCBS Quality Measure Set. The *RTC/OM: Experiences Using Transportation, RTC/OM: Meaningful Community Activity,* and *RTC/OM: Social Connectedness* measures were not specifically mentioned by the Workgroup during discussion. The Workgroup discussion centered around the two employment-related measures, *Experiences Seeking Employment* and *Job Experiences*. Several Workgroup members highlighted measures of employment as a gap in the HCBS Quality Measure Set but were conflicted about adding these two RTC/OM measures. Workgroup members reiterated their concerns from previous domain discussions about the implementation of the RTC/OM instrument in general, emphasizing that the RTC/OM measures are specified for reporting at the provider level rather than the state level and that the number of questions in each composite measure would increase administrative burden on providers administering the survey.

Workgroup members also questioned how the RTC/OM measures would align with indicators in the existing survey instruments in the measure set in terms of the HCBS populations being measured. For example, a few Workgroup members questioned whether the employment measures are appropriate for all HCBS populations, such as adults over age 65. The measure developer addressed this question by sharing that, when the RTC/OM survey was initially tested in two states, participants included all populations relevant to the HCBS Quality Measure Set and performance rates were consistent across populations. Finally, to address the comment about administrative burden, the measure developer emphasized that, for several of the measures in the RTC/OM survey, participants do not need to answer all questions due to skip patterns.

There were no public comments on these measures.

Access and Resource Allocation Domain

The Access and Resource Allocation Domain is defined as the level to which HCBS are available to all individuals who need long-term services and supports. Two measures from this domain were suggested but not recommended for removal from the HCBS Quality Measure Set:

- NCI-AD: Percentage of Non-English Speaking Participants Who Receive Information About Their Services in the Language They Prefer (22 percent of the Workgroup voted to recommend removing this measure)
- HCBS CAHPS: Transportation to Medical Appointments Composite Measure (30 percent of the Workgroup voted to recommend removing this measure)

Measures Considered and Not Recommended for Removal

Several Workgroup members noted that the *NCI-AD: Percentage of Non-English Speaking Participants Who Receive Information About Their Services in the Language They Prefer* measure is important for addressing the needs of non-English speaking individuals, and one participant emphasized that this is an area where states can have a meaningful impact. No public comments were received related to this measure.

The Workgroup also discussed the *HCBS CAHPS: Transportation to Medical Appointments Composite Measure*. One Workgroup member shared their experience in Pennsylvania, where managed care plans do not directly contract with transportation providers, meaning the plans are limited in their ability to affect measure results. The role of the plan has been to facilitate transportation for their members. Given plans' inability to influence transportation outcomes, the Workgroup member recommended removal of the measure.

One Workgroup member commented that this measure is actionable by states, as the state is likely responsible for selecting the transportation vendors and could address deficiencies identified by the measure if they arise. Two Workgroup members representing states expressed support for the measure and shared their experiences. The first individual noted that, although

New York does not use the HCBS CAHPS survey, they indicated that individual components of the composite measure can be shared with states and can be used for process improvements. Similarly, the Workgroup member from Virginia shared the measure's value in being able to compare their overall performance with other states and using the findings to drive improvements. The measure steward, CMS, commented that in discussions with Money Follows the Person demonstration states, transportation to medical appointments was raised as an important issue for measurement.

During the public comment period, a representative from the Pennsylvania Department of Human Services, Office of Long-Term Living shared that the *HCBS CAHPS: Transportation to Medical Appointments Composite Measure* has been valuable in tracking performance nationally, at the aggregate state level, as well as for each of the state's health plans and their fee-for-service waiver program. A public commenter shared that there are publicly available results for the HCBS CAHPS survey measures.

Holistic Health and Functioning Domain

Measures in the Holistic Health and Functioning Domain assess the extent to which all dimensions of holistic health are assessed and supported. Three measures from this domain were suggested but not recommended for removal from the HCBS Quality Measure Set:

- MLTSS: Plan All-Cause Readmission (43 percent of the Workgroup voted to recommend removing this measure)
- NCI-AD: Percentage of People Who Know How to Manage Their Chronic Conditions (35 percent of the Workgroup voted to recommend removing this measure)
- NCI-AD: Percentage of People With Concerns About Falling Who Had Someone Work With Them to Reduce Risk of Falls (26 percent of the Workgroup voted to recommend removing this measure)

One measure from this domain was suggested but not recommended for addition:

- NCI-AD: Percentage of People Who Can Get an Appointment to See or Talk to Their Primary Care Doctor When They Need To (57 percent of the Workgroup voted to recommend adding this measure)

Measures Considered and Not Recommended for Removal

Several Workgroup members opposed removing the *NCI-AD: Percentage of People With Concerns About Falling Who Had Someone Work With Them to Reduce Risk of Falls* measure, citing that falls are one of the leading causes of HCBS beneficiaries entering nursing facilities. One Workgroup member who opposed removing the measure felt that the *Managed Long-Term Services and Supports-5 (MLTSS-5) Screening Risk and Substantive Plan of Care to Prevent*

Future Falls measure, which is also in the HCBS Quality Measure Set, would not sufficiently monitor the risk of falls if the NCI-AD measure were removed. Workgroup members also emphasized the state's responsibility to support beneficiaries who are at higher risk of falling. One Workgroup member made a similar statement about the *NCI-AD: Percentage of People Who Know How to Manage Their Chronic Conditions* measure, arguing that states also have a responsibility to support beneficiaries with chronic conditions. Other Workgroup members questioned the actionability of the *NCI-AD: Percentage of People Who Know How to Manage Their Chronic Conditions* measure, saying that the measure does not provide meaningful information since beneficiaries' self-reported knowledge about their chronic conditions may be inaccurate.

Several Workgroup members opposed removing the *MLTSS: Plan All-Cause Readmissions* measure from the HCBS Quality Measure Set. They noted that, while hospital systems may already report on this measure, HCBS programs play a large role in preventing hospital readmissions, so it is important for states to assess readmissions from multiple perspectives. One Workgroup member from a state Medicaid agency noted that their state uses this measure to track utilization across several programs. Workgroup members who were in favor of removal said that the measure's 30-day timeframe was too long to determine the specific readmission cause, limiting the actionability of the measure. Finally, Workgroup members asked questions about the measure's technical specifications, such as the age range for the denominator and how the measure is reported in other CMS programs. A representative from CMS, the measure steward, clarified that this particular measure is specified only for individuals age 65 and older.

Measure Considered and Not Recommended for Addition

The Workgroup did not recommend the *NCI-AD: Percentage of People Who Can Get an Appointment to See or Talk to Their Primary Care Doctor When They Need To* measure for addition to the HCBS Quality Measure Set. One Workgroup member in support of addition cited that, according to the NCI-AD 2022-2023 national survey results, an average of 85 percent of HCBS beneficiaries indicated an ability to see or talk to their primary care provider, suggesting room for improvement on this measure. Another Workgroup member questioned whether a measure of whether beneficiaries see their primary care provider is within the control of an HCBS program. During the public comment period, the measure steward explained that the measure is used by managed care systems to assess their care coordination services and that primary care can be inaccessible to HCBS beneficiaries, particularly those in a fee-for-service system. A commenter from the Oregon Department of Human Services opposed adding this measure, noting that access to primary care is connected to provider availability, and that states should not be held accountable for something out of their control.

Human and Legal Rights Domain

Measures in the Human and Legal Rights Domain assess the extent to which the human and legal rights of individuals who use HCBS are promoted and protected. Three measures from this domain were suggested but not recommended for removal from the HCBS Quality Measure Set:

- NCI-AD: Percentage of People Who Are Ever Worried for the Security of Their Personal Belongings (59 percent of the Workgroup voted to recommend removing this measure)
- NCI-AD: Percentage of People Who Feel Safe Around Their Support Staff (41 percent of the Workgroup voted to recommend removing this measure)
- NCI-AD: Percentage of People Whose Money Was Taken or Used Without Their Permission in the Last 12 Months (59 percent of the Workgroup voted to recommend removing this measure)

Four measures from this domain were suggested but not recommended for addition:

- NCI-AD: Percentage of People in Group Settings Who Always Have Access to Food (55 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Feelings of Safety Around Others (25 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Freedom from Experiences of Abuse and Neglect (35 percent of the Workgroup voted to recommend adding this measure)
- RTC/OM: Knowledge of Abuse and Neglect and How to Report It (30 percent of the Workgroup voted to recommend adding this measure)

Measures Considered and Not Recommended for Removal

Throughout the discussion, Workgroup members made comments that applied to all three measures suggested for removal since all three measures share the same data source. Several Workgroup members who opposed removing the measures emphasized the importance of assessing the safety and general wellbeing of HCBS beneficiaries. They claimed that removing these measures and leaving the similar measures from the HCBS CAHPS survey on the HCBS Quality Measure Set would make cross-state comparisons on safety difficult, since not all states use HCBS CAHPS. Workgroup members disagreed in their interpretations of the measures' consistently high performance rates. Those in favor of removal argued that the high measure performance shows that states are already effective in addressing abuse through other quality improvement initiatives or HCBS regulatory requirements. Those against removal argued that some beneficiaries still face abuse despite the high performance rates and expressed concerns that not reporting on abuse may lessen states' ability to pick up on any minor changes over time. Finally, Workgroup members felt that the measures' vagueness lessens their actionability, as

surveyors may receive a wide variety of responses from beneficiaries. The measure steward clarified that they require surveyors to complete training on how to ask or rephrase the measure questions to ensure that the correct information is being captured. No public comments were received related to these measures.

Measures Considered and Not Recommended for Addition

One Workgroup member argued against adding the *NCI-AD: Percentage of People in Group Settings Who Always Have Access to Food* measure because the measure's outcome applied only to those in group settings which is a relatively small subpopulation of HCBS beneficiaries. Another Workgroup member highlighted that the measure assesses compliance with HCBS program requirements, rather than measuring HCBS beneficiary outcomes. Another Workgroup member argued against both of these points, noting that access to food in residential HCBS settings is an important requirement for states to monitor, and the subpopulation size does not diminish the state's responsibility to monitor it. Workgroup members reiterated their concerns about the RTC/OM measures from previous domain discussions, noting that the number of questions in each measure would increase data collection burden and that the measures should be tested for reporting at the state level instead of the provider level to fulfill the technical feasibility criteria.

During the public comment period, a representative from ADvancing States highlighted two other measures in the NCI-AD survey related to food access that the measure steward hopes to suggest for addition to the HCBS Quality Measure Set in the future, one assessing access to healthy foods and the other assessing skipping meals due to financial concerns.

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